# REPORT BY THE
# AUDITOR GENERAL
# OF CALIFORNIA

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**A REVIEW OF THE
DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS'
DRUG/MEDI-CAL CLAIMS PROCESS**

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**P-965** **JULY 1991**

# A Review of the Department of Alcohol and Drug Programs' Drug /Medi-Cal Claims Process

P-965, July 1991

Office of the Auditor General
California

**Kurt R. Sjoberg, Auditor General (acting)**

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July 17, 1991 P-965

Honorable Robert J. Campbell, Chairman
Members, Joint Legislative Audit Committee
State Capitol, Room 2163
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the Department of Alcohol and Drug Programs' systems for processing Drug/Medi-Cal claims and disallowances.

Respectfully submitted,

KURT R. SJOBERG
Auditor General (acting)

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## Summary

**Results in Brief**

The Department of Alcohol and Drug Programs (department) is responsible for administering a program, commonly called the Drug/Medi-Cal program, which provides reimbursement for drug treatment services to eligible beneficiaries of the California Medical Assistance program (Medi-Cal). Our audit disclosed the following weaknesses in the processing of claims for Drug/Medi-Cal services:

- A small number of providers of methadone maintenance services submitted and were paid for duplicate claims in fiscal year 1989-90;
- One county submitted and was paid for claims representing incompatible drug treatment services in at least 32 instances in fiscal year 1989-90; and
- In several instances, providers did not submit to the department disallowances of claims for drug treatment services.

**Background**

One type of drug abuse treatment reimbursable under the Drug/Medi-Cal program is methadone maintenance treatment, an outpatient service that includes counseling and the provision of methadone to alleviate symptoms of withdrawal from narcotics. Another type of treatment reimbursable under the Drug/Medi-Cal program is drug-free treatment, an outpatient service that includes counseling, but no drugs are prescribed.

The Drug/Medi-Cal program is funded by the State's General Fund and the federal Medicaid program. The federal money is paid to counties after services have been provided and approved claims for those services have been submitted to the department.

All providers that participate in the Drug/Medi-Cal program are required to have a Utilization Review Committee to review the medical necessity, appropriateness, and quality of drug treatment services. The committees are required to make disallowances of billings to the Drug/Medi-Cal program when they identify noncompliance with certain requirements.

## Stronger Systems Needed for Processing Claims and Disallowances

The system used by the department for processing Drug/Medi-Cal claims allows for payment of inappropriate claims for drug treatment services. Although we did not find significant problems, we identified a small number of duplicate payments, payments for incompatible services, and disallowances of claims that were not submitted to the department.

We conducted an automated review of approximately 32,300 claims approved for payment for drug treatment services in fiscal year 1989-90. In 25 instances, providers were paid more than once for services they provided to the same client during the same period or for services they provided to more than one client for whom they used the same identification number.

We also conducted an automated review of approximately 41,800 claims approved for payment in fiscal year 1989-90 to determine whether the department paid for incompatible services; we validated 32 instances in which one county submitted claims and received payments for incompatible services that were simultaneously provided to clients.

Finally, in our file review of 48 client charts at four providers, we identified four instances of disallowances for claims made in 1989 and 1990. However, as of May 15, 1991, the department had received the complete disallowance for only one case. In addition, we were given copies of disallowances made by a county-operated

provider that billed the department for incompatible services. Once the provider learned that its billing practice was inappropriate, it disallowed certain claims for incompatible services provided from September 1989 through May 1990 and forwarded the disallowances to the county's accounting division. However, as of May 15, 1991, the department had not received these disallowances.

These problems exist because the system used by the department to process Drug/Medi-Cal claims lacks specific controls to ensure that duplicate claims and claims for incompatible services are not approved and paid and because providers do not always follow required procedures to submit disallowances of claims to the department.

As a result of these control weaknesses, the state and federal governments are overpaying some providers for some drug treatment services. In addition, although we did not identify any specific instances, these system weaknesses create the opportunity for provider fraud, and federal funding could be at risk if inappropriate payments are not recovered.

**Recommendations**

To ensure that the systems for processing Drug/Medi-Cal claims and disallowances for claims have appropriate controls, the department should take the following actions:

- Ensure that automated edits are incorporated to screen out duplicate claims and claims for incompatible services; and
- Notify providers of the department's requirements for processing disallowances.

**Agency Comments**

The Department of Alcohol and Drug Programs concurs with the report's findings and recommendations.

## Introduction

The California Medical Assistance program (Medi-Cal), California's version of Medicaid, is a joint federal and state program intended to ensure the provision of necessary health care services to public assistance recipients and to others who cannot afford to pay for these services. The Department of Health Services is the single state department responsible for administering the Medi-Cal program. Other state departments perform Medi-Cal related functions under agreements with the Department of Health Services. The Department of Alcohol and Drug Programs (department) has an agreement with the Department of Health Services to oversee a program, commonly called the Drug/Medi-Cal program, that provides reimbursement for local drug abuse treatment services to Medi-Cal beneficiaries who are in need of such services.

One of the types of treatment reimbursable under the Drug/Medi-Cal program is methadone maintenance treatment, an outpatient service directed at stabilizing and rehabilitating clients who are dependent on narcotics such as heroin or morphine. This type of treatment includes counseling and the provision of methadone to alleviate the symptoms of withdrawal from narcotics. Another type of reimbursable treatment is drug-free treatment, which includes extensive counseling, but no drugs are prescribed. As of May 1991, 38 methadone maintenance clinics and 39 drug-free clinics were part of the Drug/Medi-Cal program.

The Drug/Medi-Cal program is funded by the State's General Fund and the federal Medicaid program. For fiscal year 1990-91, the State agreed to pay $7.6 million for the Drug/Medi-Cal

program while the Department of Health Services agreed to pay the federal share of $7.7 million. Allocations from the State's General Fund are advanced to counties each month. Counties are paid federal Medicaid money after services have been provided and approved claims have been submitted to the department.

Drug treatment services that are reimbursable under the Drug/Medi-Cal program are provided by county-operated providers or by private providers under contract with a county. All providers prepare claims that are submitted to the county. The claims allow billings for multiple beneficiaries on one form. Counties summarize the charges and submit the summary and the claims to the department, which reviews and forwards them to the Data Systems Branch of the Department of Health Services.

The Data Systems Branch processes the claims to ensure that beneficiaries were eligible during the month of service and to ensure that providers were eligible to provide services. The Department of Health Services then reports to the department whether the claims are approved, denied, or suspended. As claims are approved, the department bills the Department of Health Services for the federal share and remits the federal money to the counties. The department is responsible for recouping any inappropriate payments of federal Medicaid money that might be made.

All providers that participate in the Drug/Medi-Cal program are required to have a Utilization Review Committee to review the medical necessity, appropriateness, and quality of drug treatment services. The Utilization Review Committees must meet once a month to review new clients and requests for extended treatment. When they identify certain problems, such as a physician's late review of a client's plan for treatment or previously submitted incorrect billings, the committees are required to make disallowances of billings to the Drug/Medi-Cal program. The department must monitor Drug/Medi-Cal providers' compliance with utilization review requirements. To do this, the department's Drug/Medi-Cal Section conducts periodic on-site reviews to assess the effectiveness of the provider's

Utilization Review Committee activities and to provide technical assistance. During the course of these on-site reviews, the department may identify problems and make disallowances for billings.

If department staff have reason to suspect providers are using the Medi-Cal system to commit fraud or client abuse, they refer the case to the Department of Justice's Bureau of Medi-Cal Fraud and Patient Abuse, the unit in charge of investigating such instances.

## Scope and Methodology

The purpose of this audit was to review the potential for billing abuses in the Drug/Medi-Cal methadone maintenance program. To conduct the audit we reviewed applicable laws, rules, and regulations. We also reviewed the department's agreement with the Department of Health Services.

To determine the department's controls for monitoring providers' compliance with billing procedures of the methadone maintenance program, we examined on-site reviews of providers conducted by the department's Drug/Medi-Cal Section and audits conducted by the department's Audit Services Section. We also reviewed the requirements for the operation of Utilization Review Committees. In addition, we interviewed department staff who process Drug/Medi-Cal claims and staff from the Department of Health Services' Data Systems Branch, and we reviewed the requirements for processing claims contained in the agreement between the department and the Department of Health Services.

To determine the sufficiency of the controls for monitoring methadone maintenance providers' compliance with regulations and billing procedures, we visited a total of four providers in three counties. At each of these providers, we reviewed charts for a sample of 15 percent of the providers' clients. For the six months from October 1989 through March 1990, we tested these providers' compliance with requirements that we judged to be

critical. These requirements included having current plans for client treatment, documenting client eligibility, and documenting the number of methadone doses provided to a client. In addition, we tested whether providers' Utilization Review Committees conducted reviews within the required time frames. We identified few compliance problems that a Utilization Review Committee had not already identified and referred to the provider for correction.

To determine the sufficiency of the controls in place for monitoring the processing of Drug/Medi-Cal claims, we reviewed provider billings to Medi-Cal for the clients in our sample to determine if services billed to the Drug/Medi-Cal program were also being billed to the Medi-Cal fee-for-service program. We found no such instances. We also conducted three automated tests using the Department of Health Services' automated records of approved Drug/Medi-Cal claims for fiscal year 1989-90. To validate a sample of test results for all three automated tests, we visited four providers and reviewed client records.

## Chapter The Department of Alcohol and Drug Programs Needs To Strengthen Its Systems for Processing Drug/Medi-Cal Claims and Disallowances

### Chapter Summary

The system used by the Department of Alcohol and Drug Programs (department) for processing Drug/Medi-Cal claims allows for payment of inappropriate claims. Specifically, during our automated review, we found that, in fiscal year 1989-90, a small number of providers were paid for duplicate claims, and one county was routinely paid for claims for incompatible drug treatment services. In addition, we identified several instances of claim disallowances for drug treatment services that providers did not submit to the department as required. These problems exist because the system used by the department for processing Drug/Medi-Cal claims lacks specific controls to ensure that duplicate claims and claims for incompatible services are not approved and paid and because providers do not always follow required procedures to submit disallowances of claims to the department. As a result of these control weaknesses, the state and federal governments have overpaid some providers for some drug treatment services. In addition, although we did not identify any specific instance, these system weaknesses create the opportunity for provider fraud.

### Controls Lacking To Prevent Duplicate Payments

Title 22, Section 51470 of the California Code of Regulations states that a provider shall not submit a claim for services to a Medi-Cal beneficiary for which the provider has already received and retained payment. The department is required to ensure that any payment for drug treatment services is made pursuant to the appropriate sections of Title 22. However, we conducted an automated review of the approximately 32,300 claims approved

for payment for methadone maintenance services in fiscal year 1989-90 and found that the department had paid duplicate claims. Specifically, we found 25 instances when providers were paid more than once for methadone services they provided to the same client during the same period or for methadone services they provided to more than one client for whom they used the same identification number. These inappropriate payments totaled $7,672. Although the number of instances we identified is small and represents an error rate of only .08 percent, the potential exists for abuse of the system because duplicate claims are not detected.

Duplicate claims may be submitted in different ways. One way is when a provider lists the same client twice on claim schedules representing the same month. For example, one provider submitted claim schedules for November 1989 with one client's name listed twice, each time for the same methadone maintenance services. The claims, each for $406, were both approved and paid.

Another way duplicate claims are submitted is when a provider uses a client's identification number (either welfare identification number or social security number) more than once during the same period to claim the same type of service for more than one client. For example, we identified one instance when the system for processing Drug/Medi-Cal claims rejected an April 1990 claim for methadone maintenance services totaling $352 because the identification number was not on the Medi-Cal eligibility file. The county provided a different identification number, and the claim was then approved. However, the identification number was for a different client, a client for whom the department previously had approved and paid a Drug/Medi-Cal claim for $408 for methadone maintenance services during the same period and from the same provider. Moreover, we found that this duplicate billing was still occurring as of February 1991, ten months later. This type of inappropriate billing is being approved for payment because the automated system for processing Drug/Medi-Cal claims does not have a check, commonly referred to as an edit, to screen out duplicate claims. The department, along with the Department of Health Services, is considering implementation of such an automated edit.

We also conducted an automated review of the same sample of 32,300 claims approved for payment in fiscal year 1989-90 to identify any claims for the same client receiving methadone maintenance services from different providers during the same period. We identified no claims of this type. However, because there is no automated edit in place to screen out claims for the same client receiving methadone maintenance services from different providers simultaneously, the potential exists for abuse of the system. For example, the department would have no way of knowing if a provider with methadone programs in more than one location submitted fraudulent claims for services provided simultaneously to the same client.

## Controls Lacking To Prevent Billing and Paying for Incompatible Services

Title 9, Section 10070 of the California Code of Regulations requires counseling services, in addition to the provision of methadone, to be a part of methadone maintenance programs. By contrast, drug-free services include extensive counseling, but no drugs are prescribed. According to the supervisor of the department's Drug/Medi-Cal Section, claims for both types of service provided simultaneously to clients are not allowable. We conducted an automated review of the approximately 41,800 claims approved for payment for methadone maintenance services and drug-free services in fiscal year 1989-90. In 39 instances, one county submitted claims and received payments for both types of services that may have been simultaneously provided to clients. We visited the county and validated 32 of these instances, which accounted for claims totaling $4,372 for drug-free services and $7,588 for methadone maintenance services. Again, while the number of instances we identified is relatively small, representing an error rate of only .08 percent, and is restricted to one county, the potential exists for abuse of the system because these claims for incompatible services are made without detection.

Thirty-one clients accounted for the 39 potential instances of claims for incompatible services that we identified. In 8 of the 39 instances, the provider submitted claims for incompatible

services provided to a client for more than one month. For example, one client received both methadone maintenance services and drug-free services from the same clinic. These services were claimed and approved for February, April, and May 1990 and totaled $1,176. In another instance, a client who was receiving methadone maintenance services from one clinic was also receiving services from a second clinic, a women's perinatal drug-free program. These services were provided from August 1989 through December 1989, and the claims that were approved for these services totaled $2,030 for methadone maintenance services and $2,414 for drug-free services.

These types of inappropriate claims are being approved for payment because the automated system for processing Drug/Medi-Cal claims lacks specific edits to screen out claims for incompatible services. Although the department did, through a Drug/Medi-Cal on-site review, identify instances of billing for incompatible services that we also identified, and it made the appropriate disallowances, the department was aware of these inappropriate billings only because the clients' charts happened to be included in a sample of charts chosen for review. Without an edit in place to screen out claims for incompatible services, the department has no way of knowing whether, systemwide, similar claims are being submitted and approved for payment. The department, along with the Department of Health Services, is considering implementation of such an automated edit.

## Providers Do Not Always Submit Disallowances

Providers' Utilization Review Committees (committees) are responsible for documenting any disallowances of claims they make during reviews and forwarding them to the appropriate staff person and billing personnel. According to the department, the provider is responsible for sending to the county disallowances made by either the committee or the provider itself. The provider is required to use a standard form provided by the department to report disallowances. The county is in turn expected to forward disallowances to the department each month, along with Drug/Medi-Cal claims. However, we found that some disallowances are not being submitted to the department.

Specifically, we conducted a review of 48 client charts at four providers and identified four instances of disallowances made by committees. Three of the disallowances were made in 1989, and one was made in April 1990. However, as of May 15, 1991, the department had received the complete disallowance for only one of the four cases. The department did not receive the disallowances for two of the cases and received only a portion of the disallowance for the other case.

In one instance the committee disallowed a payment for methadone maintenance services for certain dates because the client did not receive an initial committee review within the required time frame. Although the committee made the disallowance in September 1989, the provider still had not submitted the disallowance to the department as of May 15, 1991. Consequently, the department did not recover a total of $1,060 in payments to the provider that were disallowed by the committee.

In addition to the disallowances made by the committees, we also identified several disallowances made by a county-operated provider that were not submitted to the department. These disallowances involved the simultaneous provision of both drug-free and methadone maintenance services that we discussed previously. Once the provider involved learned that it is inappropriate to bill simultaneously for both services for a single client, the provider attempted to correct its error. We noted that the county-operated provider's staff referred 32 instances of these disallowed claims for service provided between September 1989 through May 1990 to the county's accounting division. However, department records indicate that as of May 15, 1991, only one of the 32 disallowances was submitted to the department.

In one instance, in July 1990, the county-operated provider disallowed $168 in previously billed drug-free services because the client received the services while enrolled in a methadone maintenance program. However, as of May 15, 1991, the department had not received this disallowance.

According to the supervisor of the Drug/Medi-Cal Section, during their on-site reviews, staff trace disallowances from the provider to the department on a sample basis. However, because disallowances result in a recoupment of payments made to providers, providers have little incentive to consider processing disallowances a priority. Because federal funding may be at risk if disallowances are not made and inappropriate payments recovered, it is important that the department stress to providers the necessity of following the procedures for processing disallowances.

## Effects of System Weaknesses

While our review did not disclose significant amounts of overpayments, it did identify weaknesses in the controls over the system that could detect overpayments. Because the system for processing Drug/Medi-Cal claims lacks automated edits to ensure that payments are not made for duplicate claims or incompatible services, the state and federal governments are overpaying some providers for some drug treatment services. In addition, when providers do not submit to the department instances of disallowances for previously paid claims for drug treatment services, the state and federal governments also are paying too much. Further, there is an opportunity for providers to submit claims fraudulently by taking advantage of system weaknesses. If not corrected, these weaknesses could jeopardize the federal funding of the department's drug treatment programs.

## Conclusion

The system for processing Drug/Medi-Cal claims lacks automated edits to screen out duplicate claims, claims for the same services provided simultaneously to the same client by different providers, and claims for incompatible services. During our review, we found that in fiscal year 1989-90, a small number of providers were paid more than once for methadone services they provided to the same client during the same period or for methadone services they provided to more than one client for whom they used the same identification number. Further, one provider was

routinely paid for claims for incompatible drug treatment services. We also found that providers do not always submit to the department disallowances for claims for drug treatment services. As a result of these weaknesses, the state and federal governments have overpaid some providers for some drug treatment services. In addition, the opportunity exists for provider fraud, and federal funding could be at risk.

**Recommendations**

To improve the systems for processing Drug/Medi-Cal claims and disallowances for claims, the department should take the following actions:

- Ensure that an automated edit is incorporated to screen out claims for the same services provided during the same period to the same client or to different clients for whom the same identification number is used;

- Ensure that an automated edit is incorporated to screen out claims made by different providers for the same services provided simultaneously to the same client;

- Ensure that an automated edit is incorporated to screen out claims for incompatible services provided to the same client during the same period;

- Notify providers of drug treatment services of the department's requirements for processing disallowances and remind providers of the importance of following these processes; and

- Recover all overpayments identified in the Office of the Auditor General's review.

We conducted this review under the authority vested in the auditor general by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

KURT R. SJOBERG
Auditor General (acting)

Date: July 15, 1991

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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

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July 9, 1991

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Dear Mr. Sjoberg:

REPORT P-965

Secretary Gould has asked me to respond to the report on the Department of Alcohol and Drug Programs' Drug/Medi-Cal Claims Process, P-965. Overall, the Department of Alcohol and Drug Programs concurs with the report. Specific responses to the recommendations follow:

1. The Department is working with the Department of Health Services, Fiscal Intermediary Branch, to incorporate edits to the existing automated billing system to address the problems of duplicate payments for same clients, to screen for incompatible services, and to identify claims made by different providers for the same services to the same client. We expect these edits to be incorporated for Fiscal Year (FY) 1991-92 claims.

2. The Department is considering changing the reporting of disallowances by making changes in the number of copies of the form and the routing of the documents. The provider would be required to send the first copy to the county plus a copy to the Department. Disallowances would be reconciled after being formally submitted by counties; however, the Department would have the capability of following up to ensure counties report them as required. When finalized, this change will also apply for FY 1991-92.

3. As soon as the specific information regarding overpayments is received from the Office of the Auditor General, the Department will take the necessary steps to retrieve the overpayments.

Thank you for the opportunity to review and comment on this report. We also appreciate the cooperative, professional spirit in which your staff conducted this review.

Sincerely,

ANDREW M. MECCA, Dr.P.H.
Director

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
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Capitol Press Corps